Authorization For AHCCCS To Disclose Protected Health Information

(For use by AHCCCS members who want AHCCCS to disclose their protected health information to another person/entity)

Name:	AHCCCS ID Number or ACN:
Date of Request:	Date of Birth:

I give my permission for AHCCCS to disclose my protected health information to:

Name and Address:

_____

_____

_____

_____

Name and Address:

_____

_____

_____

_____

(If you need more space, please attach an additional sheet)

Please choose one of the following:

☐ I specifically authorize AHCCCS to disclose all of my protected health information in its possession to the people listed above.

☐ I specifically authorize AHCCCS to disclose only the health information described here:

_____

_____

_____

Please choose one of the following:

☐ This disclosure is being made at my request and I choose not to state the reason for this disclosure.

☐ I specifically authorize the disclosure of my health information for the following purpose(s):

_____

By placing my initials in front of any of the following items, I specifically authorize AHCCCS to disclose the following: [NOTE: FEDERAL REGULATIONS REQUIRE A DESCRIPTION OF THE REASONS FOR DISCLOSING SUBSTANCE ABUSE INFORMATION.]

_____ HIV/AIDS and communicable disease related information and/or records
_____ Mental health information and/or records
_____ Genetic testing information and/or records
_____ Drug/alcohol diagnosis, treatment/referral information for the following purposes:

_____

_____

By signing this Authorization, I understand that:

- If the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed again by that person or entity, and your information will no longer be protected by the regulations. However, the Federal Substance Abuse Confidentiality Requirements may prohibit any further disclosure.

- I may refuse to sign this authorization, and my refusal will not affect my eligibility for benefits.

- I may inspect or copy any information to be disclosed under this authorization.

- I may **revoke** this authorization, in writing, at any time, by completing an AHCCCS "Revocation of Authorization" form, and sending it to:

  Arizona Health Care Cost Containment System
  Office of Legal Assistance, Attention: Privacy Officer
  701 E. Jefferson, MD 6200
  Phoenix, AZ 85034
  Phone 602-417-4232 Fax 1-602-253-9115

Once AHCCCS receives the revocation, this authorization will be revoked, except to the extent that AHCCCS has already taken action in reliance upon this authorization.

Please choose one of the following:

This authorization will expire on:

☐ Insert specific date: _____

☐ Insert specific event: _____

Member or Member's Representative

Signature:	Date:
Name of Member or Member Representative	Representative's Relationship to Member
For AHCCCS use only: Received by _____	Date of Receipt _____